Freestate ChalleNGe Academy Medical Forms
* Bldg E 4230 Beal Road * Aberdeen Proving Ground * Maryland 21010
Office 410-436-3220 or 410-436-3231

Medical Form's Checklist

APPLICANT'S NAME: _____DATE: _____

_____ How to have your Child Medically Prepared (page 3)

_____ Medical History (page 4)

_____ Psychological History (page 5)

_____ Medical Evaluation Form (Part 1 and Part 2) (page 6 and 7) FCA physical form within nine months of the class start date.

_____ Prescription Medication or Over The Counter Medication release form (page 8)

_____ Immunization Records or (DHMH Form 896 Rev. 2/11) (page 9)

- See page 2 for Required Immunizations

_____ Over The Counter (OTC) Formulary (pages 10-13)

- Signed by Parents/Guardian and Physician

_____ STD Form with Results (page 14)

_____Your application will be considered but, cannot be forwarded to the Director for final approval until all of the documents listed above are received.

Notes:

- Packet must be completely filled out and brought to the Pre-in-process event. You must attend **Dec 6, 2014 at 0900 hours** to have your medical paperwork reviewed.
- **Do Not Fax Paperwork.**
- If any question please call **Mr. Clay Maas** at **410 436-3236** and leave a message. I will call you back.

Immunization Records (DHMH fm 896)

- Completed Hepatitis B Series (All 3 Shots)
- Varicella shot or History of Chickenpox
- Meningococcal Shot (for residential setting)
- Proof of Current FLU shot (If entering the January Class)
- Tetanus shot within 10 years
- Measles, Mumps, Rubella (MMR)(Proof of 2 Shots)

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To: Parent and/or Guardian

From: Freestate Challe**NG**e Academy Medical Department

Subject: Everything Required by Medical Department.

Below is a list of everything required by the Medical Department for in-processing.

FORMS TO BE COMPLETED BY PARENT AND/OR GUARDIAN

- How to Have Your Child Medically Prepared
- Medical History Form
- Parental Consent for Medical Care (To Be Completed at Time of Interview)
- Psychological History

FORMS TO BE COMPLETED BY PHYSICIAN

- Medical Evaluation of Student for Participation in the Academy
  * Exam Must Be **LESS** Than 9 (NINE) Months Old at Class Start Date
  * PPD (tuberculin test) Results Must Be Annotated on Physical Exam
- Physician's Authorization for Prescription & OTC Medication
  Note: ONE FORM FOR **EACH** MEDICATION (prescription &/or non-prescription).
- Completed **MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE IMMUNIZATION CERTIFICATE FORM 896**, …no other form is acceptable… to include completed:

  * Hepatitis B series (all 3 shots)
  * Current tetanus booster (within the last ten years),
  * Meningococcal,
  * Varicella (or date of history of disease),
  * MMR (proof of two shots)
  * If starting in the January class you must have a current **FLU** vaccination.
  * All applicants must meet Maryland State immunization requirements for entrance into Freestate ChalleNGe Academy.
- Copy of Signed Over-The-Counter (OTC) Formulary to be completed by the parent/guardian **and** the physician
- STD Screening Information Form

IF YOU HAVE ANY QUESTIONS CONCERNING THE MEDICAL FORMS PLEASE CONTACT MR. CLAY MAAS AT 410-436-3236

How To Have Your Child Medically Prepared

1. Make sure that your child has had all necessary medical appointments before the scheduled in-processing date.

a. **DENTAL APPOINTMENTS**: Make sure routine dental appointments are made before or after the program ends. Dental appointments will only be made in emergency situations. All other appointments will be made after the program ends. If cadet is having Orthodontic follow-up, please make sure they have a visit scheduled prior to start of program and have a statement from the Orthodontist concerning how many weeks before the next follow-up. Do not schedule a date. Follow-up dates must be coordinated with the medical department and can only occur on non-academic days.

b. MEDICAL APPOINTMENTS: Will be made through the medical department. Your child can be picked up on the day of the appointment and must return immediately following appointment. Medical appointments can only occur on non-academic days.

c. EYE APPOINTMENTS: Please make sure that your child has had their routine eye exam before entering the program. Make sure they bring current prescription glasses with them. Glasses that "darken" when the child goes outside are NOT authorized. Non-emergency routine follow-up eye appointments will only be made after the program ends.

d. CONTACT LENSES: If your child has contact lenses they must get prescription glasses for the program. Contact lenses are not authorized. Students are not allowed to have contact lenses while at the Academy. Glasses must be clear lens and cannot darken in the sunlight.

2. If your child is currently taking any prescription medication(s) please continue these medications. Do not stop medications unless directed by your physician.

a. PRESCRIPTION MEDICATIONS: Please remember to bring all prescribed medication and medication authorization forms (filled out by your physician) to in-processing.

b. If over-the-counter medications are taken on a regular or seasonal basis, a medication authorization form must be filled out **&** signed by your physician.

Parent/Guardian Signature: _____Date _____

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MEDICAL HISTORY
TO BE COMPLETED BY PARENTS &/OR GUARDIAN

Cadet's Name: _____
(LAST) (FIRST) (MI)

1. Has your child had or been advised to have an operation? _____yes _____no
If yes, please explain_____
2. Has your child ever been a patient in a hospital? _____yes _____no
If yes, please explain_____
3. Has your child ever lived in a group home? _____yes _____no
Has your child ever lived in a boarding school? _____yes _____no
Has your child ever lived in a residential treatment program? _____yes _____no
4. Does your child use tobacco? _____yes _____no
If yes, cigarettes, cigars. smokeless tobacco?
How many/much per day? _____
5. List **any** illness or injuries not previously mentioned.
_____
_____
6. List the names of **any** medications your child is currently taking._____
_____
7. Last menstrual cycle? _____(Females)
8. Last PAP Smear? _____(Females)
9. Last dental appointment? _____
10. List **any** medications to which your child is allergic. _____
_____
11. List **any** allergies (food, insects, seasonal, etc.) that your child has.

_____
_____
_____
_____
_____

Nearest relative we can contact in case of emergency when <u>you</u> are unavailable.

Name: _____

Relationship to Patient: _____

Address: _____City _____Zip Code _____

Phone number: HOME:__(_____)_____
WORK__(_____)_____
CELL:__(_____)_____

PSYCHOLOGICAL HISTORY

Name of Applicant:_____
(LAST) (FIRST) (MI)

1. Are you now or have you ever seen a psychiatrist, psychologist, social worker, counselor or other professional for **ANY** reason? _____**YES** _____**NO**
If **YES**, you must provide written documentation and most recent report.

2. Are you now or have you ever seen a counselor or been treated (inpatient and/or outpatient) for alcohol abuse/problems, drug abuse/problems (to include legal or illegal drugs), substance abuse/problems or any other addiction or addictive behavior?
_____**YES**_____**NO**
If **YES**, you must provide written documentation and most recent report.

3. Are you now or have you ever been evaluated, treated, recommended for treatment, or hospitalized as an inpatient or outpatient for depression, suicidal thoughts or attempts, self mutilation/cutting, violent behavior?
_____**YES** _____**NO**
If **YES**, you must provide written documentation and most recent report.

4. Are you now or have you ever been evaluated or treated for sexual or physical abuse?
_____**YES**_____**NO**
If **YES**, you must provide written documentation and most recent report.

5. Are you now or have you ever been evaluated, treated, recommended for treatment, or hospitalized as an inpatient or outpatient for mood or anxiety disorders, hallucinations, paranoia, bipolar disorders?
_____**YES** _____**NO**
If **YES**, you must provide written documentation and most recent report.

6. Are you now or have you ever taken medications, drugs, or any other substances to improve your attention, behavior and or physical performance? _____**YES** _____**NO**
If **YES**, please list the names of any and all medications, drugs, substances:
_____
_____
_____

7. Are you now or have you ever taken psychotropic medications in the past two years?
_____**YES** _____**NO**
If **YES**, please list the names of any and all medications, drugs, substances:
_____
_____

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PART-1 MEDICAL EVALUATION FORM

(To be completed by Parent or Guardian and submitted to the examining physician before he/she examines)

Name of Student _____ Last First Middle

Date of Birth ___/___/___ **ALLERGIES** _____

Parent _____ **Address** _____ **Home Phone** ( )

Personal Health of Student — Check correct	YES	NO
1. Has had injuries or accidents requiring medical attention	☐	☐
2. Has had surgical operation	☐	☐
3. Has been in hospital	☐	☐
4. Has had sickness lasting longer than one week	☐	☐
5. Takes medicine now or regularly	☐	☐
6. Has a condition now under a physicians care	☐	☐
7. Has a defect in hearing or eyesight (glasses) _____	☐	☐
8. Is there any reason this student should not participate?	☐	☐

If you answered "YES" to any of the above questions, explain below with names and dates:

_____

_____

_____

_____

9. To my knowledge the paired organs that follow are present and healthy

	YES	NO
Ears _____	☐	☐
Eyes _____	☐	☐
Lungs _____	☐	☐
Kidneys _____	☐	☐
Testicles and Ovaries _____	☐	☐
Arms/Legs _____	☐	☐
Fingers/Toes _____	☐	☐

* If you answered "NO" to any of the above questions in # 9 please explain below.

_____

_____

_____

_____

I GIVE PERMISSION FOR THE PHYSICIAN TO COMPLETE PART 2 OF THIS FORM FOR CONFIDENTIAL USE IN MEETING MY CHILD'S HEALTH AND EDUCATIONAL NEEDS.

_____ _____

PARENT OR GUARDIAN SIGNATURE **DATE**

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PART-2: MEDICAL EVALUATION FORM
(Must be completed by physician or under his/her supervision)

Name of Student _____ Allergies _____
Last First Middle

Significant past illnesses or injuries: _____

PHYSICIANS EXAMINATION: (CIRCLE AND EXPLAIN ABNORMAL FINDINGS)

Height _____	Weight _____	Blood Pressure _____	Pulse _____
Eyes _____		Visual Acuity R ____/____	L ____/____
Ears _____		Hearing R ____/____	L ____/____
Nose (deformities) _____		Oropharynx _____	
Teeth (cavities, dentures, braces) _____		Respiratory _____	
Breast (M&F) _____		Cardiovascular (pedal pulse) _____	
Abdomen (hernia, spleen, liver) _____		Genitalia and anus _____	
Neuromuscular _____		Skin _____	
Spine (cervical, thoracic, lumbar) _____			
Extremities (special attention to knees & ankles) _____			
Additional explanations of abnormal findings _____			

Laboratory
Urinalysis: Protein _____
Sugar _____
Other _____

Must have
TUBERCULIN TEST
Tuberculin test _____
OR
Chest X-Ray _____
(Results/date)

I have on this date **personally** examined this student, reviewed the history and find the student physically able to participate in supervised activities listed below.

STRETCHES

Abdominal	Groin Seated
Chest	Groin Standing
Upper Back	
Hamstring	

EXERCISES

Push-ups	Sit ups
Knee bends	Marching
Road Marching	Side Straddle Hop
Multiple arm Movements	Chin ups

ENVIRONMENTAL FACTORS

Grass/ Trees
Mold
Animals (deer, raccoons, Squirrels, etc.)
Air Quality (such as humid days)

MUST HAVE OFFICE STAMP TO BE VALID

_____
Physicians Signature Date Phone Number

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Physician's Authorization For

PRESCRIPTION MEDICATION

or

OVER-THE-COUNTER MEDICATION

PLEASE MAKE A COPY THIS FORM IF THE PHYSICIAN WRITES FOR MORE THAN ONE MEDICATION FOR STUDENT

CLASS NO_____ **FULL NAME OF STUDENT**_____

- I understand that I must supply the school with the equipment/supplies needed to administer the medication.
- I understand that all medications must be labeled with the name of the medication, name of student, name of physician, date, and directions for administration. Prescription medication must be labeled by a registered pharmacist.
- I hereby authorize the medication described below to be administered as directed by my child's physician.
- I understand that the physician will be called if a question arises about my child's medication.
- I understand I will be notified when a prescription needs to be refilled and that I must get medication refilled and either bring or send the medication to the medical section in a timely manner.
- 911 will be called immediately in an emergency.

_____ _____

Signature of Parent/Guardian Date

FOR COMPLETION BY PHYSICIAN

NOTE: Per Maryland Law Only One Medication Allowed Per Form

1. Name of medication _____
2. Reason for medication _____
3. Type of device _____
4. Specific direction for use _____
   - Is the student capable of self-administering the medication by device? [ ] Yes [ ] No
   - Should the student carry medication and device with him/her? [ ] Yes [ ] No
5. Dosage of medication _____
6. Time of day medication is to be given _____
7. Date to Begin Medication _____ Date to Discontinue Medication _____
8. Side effects _____

Physicians Signature:_____

Physicians Printed Name & Phone Number:_____

Reviewed By MYC Medical Department:_____

MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE IMMUNIZATION CERTIFICATE

CHILD'S NAME _____
LAST FIRST MI

SEX: MALE ☐ FEMALE ☐ BIRTHDATE _____/_____/_____

COUNTY _____ SCHOOL _____ GRADE _____

PARENT OR GUARDIAN NAME _____ PHONE NO. _____

ADDRESS _____ CITY _____ ZIP _____

RECORD OF IMMUNIZATIONS (See Notes On Other Side)

Vaccines Type

Dose #	DTP-DTaP-DT Mo/Day/Yr	Polio Mo/Day/Yr	Hib Mo/Day/Yr	Hep B Mo/Day/Yr	PCV Mo/Day/Yr	Rotavirus Mo/Day/Yr	MCV Mo/Day/Yr	HPV Mo/Day/Yr	Dose #	Hep A Mo/Day/Yr	MMR Mo/Day/Yr	Varicella Mo/Day/Yr	History of Varicella Disease Mo/Yr
1									1				
2									2				
3										Td Mo/Day/Yr	Tdap Mo/Day/Yr	FLU Mo/Day/Yr	Other Mo/Day/Yr
4													
5													

To the best of my knowledge, the vaccines listed above were administered as indicated.

1. _____
Signature Title Date
(Medical provider, local health department official, school official, or child care provider only)
2. _____
Signature Title Date
3. _____
Signature Title Date

Lines 2 and 3 are for certification of vaccines given after the initial signature.

Clinic / Office Name
Office Address/ Phone Number

LOST OR DESTROYED RECORDS: (Must be reviewed and approved by a medical provider or the local health department. See notes)

I hereby certify that the immunization records of this child have been lost, destroyed or are unobtainable.

Signed: _____ Date: _____
Parent or Guardian

COMPLETE THE APPROPRIATE SECTION BELOW IF THE CHILD IS EXEMPT FROM IMMUNIZATION ON MEDICAL OR RELIGIOUS GROUNDS. ANY IMMUNIZATIONS THAT HAVE BEEN RECEIVED SHOULD BE ENTERED ABOVE.

MEDICAL CONTRAINDICATION:
The above child has a valid medical contraindication to being immunized at this time.

This is a ☐ permanent condition ☐ temporary condition until _____/_____/_____

Check appropriate box, indicate vaccine(s) and reasons: _____

Signed: _____ Date _____
Medical Provider / LHD Official

RELIGIOUS OBJECTION:
I am the parent/guardian of the child identified above. Because of my bona fide religious beliefs and practices, I object to any immunizations being given to my child. This exemption does not apply during an emergency or epidemic of disease.

Signed: _____ Date: _____

DHMH Form 896
Rev. 2/11

Center for Immunization
www.EDCP.org (Immunization)

Over-The-Counter (OTC) Formulary

(Must be reviewed by parents/guardians and doctor)

ORAL MEDICATIONS

NAME: Alamag (Similar to Maalox)
USES: Heartburn, Sour Stomach, Acid Indigestion, Upset Stomach

NAME: Non-Aspirin 325 mgm (Similar to Tylenol)
USES: Headache, Common Cold, Muscular aches, Toothache, Menstrual cramps

NAME: Non-Aspirin Extra Strength 500mgm (Similar to Extra Strength Tylenol)
USES: Headache, Common Cold, Muscular Aches, Toothache, Menstrual Cramps

NAME: CCP (Similar to Generic Cold Capsules)
USES: For the temporary relief of minor aches and pains associated with headache, common cold, muscular aches, toothache, minor arthritis pain, menstrual cramps.

NAME: Cramp Tabs (Similar to Midol) …**FOR FEMALES ONLY**…
USES: Cramps, headache, bloating, backaches, water-weight gain, muscular aches and pains.

NAME: Decorel Forte Plus (Similar to generic cold capsules)
USES: Cough, Sore Throat, Minor Aches & Pains, headaches, nasal congestion, helps loosen phlegm, temporarily reduces fever.

NAME: Diamode 2 mgm (Similar to Lomotil)
USES: Controls the symptoms of diarrhea

NAME: Diotame (Similar to Pepto Bismal)
USES: Upset Stomach, Heartburn, Indigestion, Diarrhea, Nausea

NAME: Diphen 25 mgm (Similar to Benadryl)
USES: Hay Fever, Upper Respiratory Allergies, Runny Nose, Sneezing, Itchy Watery Eyes, Itching of the Nose or Throat

NAME: Guaifenesin Oral Solution (Similar to Robitussin)
USES: Helps loosen phlegm (mucus) and thin bronchial secretions to make coughs more productive

NAME: Ibuprofen 200 mgm
USES: Common Cold, Backache, Headache, Toothache, Menstrual Cramps, Muscular Aches

NAME: Loradamed 10 mgm (Similar to Claritin)
USES: Temporary relieves symptoms due to hay fever or other upper respiratory allergies

NAME: Medi-Graine (Similar to Excedrin)
USES: Headache, Muscular Aches, Common Cold, Toothache, Menstrual Cramps

NAME: Mediproxen (Similar to Naproxen 220mg)
USES: Headache, Back Ache, Muscular Aches, Common Cold, Toothache, Menstrual Cramps

NAME: Metamucil
USES: Promotes Bowel Movements, Relieves Constipation

NAME: Milk of Magnesia
USES: Promotes Bowel Movements,

NAME: MYGREX (Similar to Tylenol Sinus Headache Relief)
USES: For the temporary relief of minor sinus pain and headaches and for the relief of nasal congestion.

NAME: Sepasoothe (Similar to Cepacol)
USES: For the temporary relief of pain and discomfort associated with minor sore throat, tonsillitis and pharyngitis.

NAME: Silexin (Similar to Robitussin)
USES: Temporarily relieves cough due to minor throat and bronchial irritation, temporarily helps to suppress the cough reflex, helps loosen phlegm and make coughs more productive.

NAME: Sinus Decongestant (Phenylephrine Hcl 10 mgm) (Similar to Sudafed)
USES: Temporarily relieves nasal congestion due to the common cold, hay fever or other upper respiratory allergies.
NAME: TUMS Tablets
USES: Relief of Acid Indigestion, Heartburn and Sour Stomach

TOPICALS

NAME: Anbesol Oral Anesthetic
USES: Temporarily relieves pain associated with mouth and gum irritations, toothache, sore gums, canker sores, braces, minor dental procedures and dentures

NAME: Bactine First Aid Liquid
USES: Used to help bacterial contamination of skin associated with minor cuts, scrapes, burns, sunburn and skin irritations

NAME: Bacitracin Antibiotic Ointment
USES: Minor Cuts, Scrapes, Burns

NAME: BioFreeze
USES: Temporary relief from minor aches and pains of sore muscles and joints associated with backache, strains and sprains.

NAME: Calamine Lotion
USES: Dries the oozing and weeping of poison ivy, poison oak and poison sumac

NAME: First Aid Burn Cream
USES: Minor Cuts, Scrapes, Burns

NAME: Hemorrhoidal Ointment
USES: Helps relieve local itching & discomfort with hemmorrhoids

NAME: Hydrocortisone Cream 1%
USES: For the temporary relief of itching associated with minor skin irritations and rashes.

NAME: Ivarest
USES: Relief from itching and rash associated with poison ivy, poison oak, poison sumac or insect bites.

NAME: Lip Guard (Similar to Blistex)
USES: For the temporary relief of pain and itching associated with minor lip irritations, chapped or cracked lips and itching associated with cold sores

NAME: Medi-First Antifungal Cream
USES: Athlete's Feet, Jock Itch, Ringworm

NAME: Natrapel Plus Insect Repellent
USES: Repels mosquitoes, Blackflies, biting midges & "no-see-ums".

NAME: TECNU Outdoor Skin Cleanser
USES: Removes Poison Oak & Ivy Oils That Cause Rash and Itching

NAME: Triple Antibiotic Ointment
USES: Minor Cuts, Scrapes, Burns

NAME: Vitamin A & D Ointment
USES: Minor Burns, Scalds, Sunburn, Windburn, Diaper Rash, Chafing, Chapped Skin, Nipple Care, Abrasions, Cuts, Ulcers

MISCELLANEOUS

NAME: Debrox, Earwax Removal Aid
USES: For occasional use as an aid to soften, loosen, and remove excessive earwax.

NAME: Eye Wash, Sterile Isotonic Buffered Solution
USES: To help flush loose foreign material or chemicals from the eye. To help relieve eye irritation, burning, itching or stinging.

NAME: Hemorrhoidal Suppositories 9Similar to "Preparation-H" Brand)
USES: Temporarily relieves itching, burning and discomfort of hemorrhoids

NAME: Insta-Glucose (24 GMS of carbohydrate)
USES: Insulin Reactions, Diabetic emergencies

NAME: Moisture Eyes, Preservative Free
USES: Lubricant Eye drops, Artificial Tears, Moisturizes Dry Eyes.

NAME: Nasal Decongestant Spray (Similar to AFRIN)
USES: For the temporary relief of nasal decongestion due to the common cold, hay fever or other upper respiratory allergies.

NAME: Opcon-A Eye Drops
USES: Temporarily relieves itching and redness caused by pollen, ragweed, grass, animal hair and dander.

NAME: Opti-Clear Eye Drops
USES: Relieves redness of the eye caused by minor eye irritations.

NAME: Orasol Gel

USES: For the temporary relief of minor pain and sore mouth associated with toothache, cold sores, minor dental procedures, and irritations from dentures or orthodontic appliances.

NAME: PRO QR Nosebleeds
USES: Stops bleeding from minor external wounds

NAME: Swim-EAR
USES: Dries water in the ears and relieves water-clogged ears.

****

PARENTAL AGREEMENT

I/we, the parents/guardians of _____ have reviewed and approved the above listing of over-the-counter medications for use on our child in the event of any minor illness or injury. Any item I/we feel is inappropriate for use will be **crossed out**, **initialed** and **dated** as in the example below.

TAKE THIS TO THE SAME PHYSICIAN WHO PERFORMS THE CADETS PHYSICAL EXAMINATION. PHYSICIANS SIGNATURE REQUIRED.

NAME: Calamine Lotion *(your initials/ today's date)*
USES: Dries the oozing and weeping of poison ivy, poison oak and poison sumac

Parent Signature:_____

PHYSICIAN CONCURRENCE

I have reviewed and approved the listing of over-the-counter medications for use on cadet_____ in the event of any minor illness or injury. Any item I feel is inappropriate for use will be crossed out, initialed and dated as in the example below.

NAME: ~~Calamine Lotion~~ *(your initials / today's date)*
USES: Dries the oozing and ~~weeping~~ of poison ivy, poison oak and poison sumac
DIRECTIONS: ~~Apply liberally as often as necessary.~~

PRINTED NAME OF PHYSICIAN:_____

PHYSICIANS SIGNATURE:_____

STD TEST FORM

This is to verify that Cadet _____

Was seen at _____

On _____, for their <u>mandatory</u> Sexually Transmitted Disease

examination. Testing is NOT optional. The following STD screenings <u>must</u> be performed:

<u>Name</u>	**<u>Date of Exam</u>**
Syphilis	_____
Gonorrhea	_____
Chlamydia	_____
Pregnancy Test	_____

This screening is to ensure that each cadet received proper medical evaluation and is extended any necessary treatment and/or follow-up appointments with a physician.

Physician's signature: _____Date: _____

Attach a copy of the test results to this form. The test results are required for admission into this program.

"No Test Results = No Admission"